7.d. Physical therapy, occupational therapy or speech pathology and audiology services provided by a home health or medical rehabilitation agency.

For services provided by a **home health agency**, payment is the lower of:

(1) submitted charge; or

(2) Medicare cost-per-visit limits based on Medicare cost reports submitted by free-standing home health agencies in the Minneapolis and St. Paul area in calendar year 1982.

Procedure Code	July 1, 1997	July 1, 1998	July 1, 1999
X5280 Physical Therapy Visit	$49.51/visit	$51.00/visit	$53.04/visit
X5281 Speech Therapy Visit	$50.27/visit	$51.78/visit	$53.85/visit
X5282 Occupational Therapy Visit	$50.53/visit	$52.05/visit	$54.13/visit
X5283 Respiratory Therapy Visit	$36.75/visit	$37.85/visit	$39.36/visit

Services provided by **rehabilitation agencies** are paid using the same methodology as item 5.a., Physicians' services, except that payments are increased by 38% for physical therapy, occupational therapy, and speech pathology services provided by an entity that:

(1) is licensed under Minnesota Rules, parts 9570.2000 to 9570.3600 that operate residential programs and services for the physically handicapped;

2) is Medicare certified as a comprehensive outpatient rehabilitation facility as of January 1, 1993; and

(3) for which at least 33% of the patients receiving rehabilitation services in the most recent calendar year are recipients of medical assistance, general assistance medical care, and MinnesotaCare.

8. Private duty nursing services.

Payment is the lower of the submitted charge; or the following:

Procedure Code	January 1, 1993	July 1, 1994	July 1, 1997	July 1, 1998	July 1, 1999
X5641 Independent Private Duty R.N.	$3.71/unit	$3.82/unit	$4.01/unit	$4.13/unit	$4.30/unit
X5642 Independent Private Duty L.P.N.	$2.78/unit	$2.86/unit	$3.00/unit	$3.09/unit	$3.21/unit
X5646 Private Duty R.N.	$5.49/unit	$5.65/unit	$5.93/unit	$6.11/unit	$6.35/unit
X5647 Private Duty R.N. (for vent dependent recipient)	$6.18/unit	$6.37/unit	$6.69/unit	$6.89/unit	$7.17/unit
X5648 Private Duty L.P.N.	$4.20/unit	$4.33/unit	$4.55/unit	$4.69/unit	$4.88/unit
X5649 Private Duty L.P.N. (for vent dependent recipient)	$4.89/unit	$5.04/unit	$5.29/unit	$5.45/unit	$5.67/unit

NOTE: 1 unit = 15 minutes

Shared care: For two recipients sharing care, payment is one and one-half times the payment for serving one recipient who is not ventilator dependent. This paragraph applies only to situations in which both recipients are present and received shared care on the date for which the service is billed.

9. Clinic services.

Clinic services are paid using the same methodology as item 5.a., Physicians' services, except ~~that~~:

- dental services provided by clinics are paid using the same methodology as item 10, Dental services

- end-stage renal disease hemodialysis provided by renal dialysis clinics is paid using the same methodology as item 2.a., Outpatient hospital services

10. Dental services.

Payment is the lower of:

(1) submitted charge; or

(2)(a) 91.6% of the 50th percentile of the charges submitted by all dental service providers in the calendar year specified in legislation governing maximum payment rates. Effective July 1, 1997, this is increased by five percent, effective January 1, 1999, by three percent, and effective January 1, 2000, by three percent; or

(b) State agency established rate.

The agency has established rates for the following services:

Procedure Code	5/14/93	7/1/97	7/1/98	1/1/00
D5211	$294.50	$309.22	$318.49	$328.04
D5212	$342.00	$359.10	$369.87	$380.96

Procedure Code	6/1/94	7/1/97	7/1/98	1/1/00
D5510	$71.94	$75.53	$77.79	$80.12
D5520	$70.57	$74.09	$76.31	$78.59
D5610	$71.94	$75.53	$77.79	$80.12
D5620	$105.37	$110.63	$113.94	$117.35
D5630	$84.51	$88.73	$91.39	$94.13
D5640	$70.57	$74.09	$76.31	$78.59
D5650	$110.21	$115.72	$119.19	$122.76
D5660	$84.51	$88.73	$91.39	$94.13

10. Dental services. (continued)

X-ray services are paid according to the dental services methodology listed above.

Tooth sealants and **fluoride treatments** are paid at the lower of:

(1) submitted charge; or
(2) 80% of the median charges submitted in 1997.

Effective January 1, 2000, the rate is increased by three percent.

Medical and surgical services (as defined by the Department) furnished by dentists are paid using the same methodology as item 5.a., Physicians' services.

11. Physical therapy and related services.

See items 11.a. through 11.c.

11.a. Physical therapy.

Physical therapy services are paid using the same methodology as item 5.a., Physicians' services.

Physical therapy assistants are paid the lower of:

(1) submitted charge; or

(2) 100% of the fee schedule rate if the services are provided under the direction of the physical therapy who is on the premises; or

(3) 65% of the fee schedule rate if the services are provided when the physical therapist is not on the premises.

11.b. Occupational therapy.

Occupational therapy services are paid using the same methodology as item 5.a., Physicians' services.

Occupational therapy assistants are paid the lower of:

(1) submitted charge; or

(2) 100% of the fee schedule rate if the services are provided under the direction of the occupational therapist who is on the premises; or

(3) 65% of the fee schedule rate if the services are provided when the occupational therapist is not on the premises.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).

Speech, language, and hearing therapy services are paid using the same methodology as item 5.a., Physicians' services.

12. Prescribed drugs, dentures, and prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

See items 12.a. through 12.d.

12.a. Prescribed drugs.

Payment is determined in accordance with 42 CFR §§447.331 to 447.333. Payment for prescription drugs is the lower of:

(1) the actual acquisition costs of the drugs, plus a fixed dispensing fee;

(2) the maximum allowable cost set by the State agency not to exceed in the aggregate the upper limits established under 42 CFR §447.332 for multiple source drugs, plus a fixed dispensing fee; or

(3) the provider's usual and customary charge to the general public.

The State agency establishes the actual acquisition cost to equal 91% of the average wholesale price.

With the following exceptions, the dispensing fee is $3.65 plus an additional $.30 dispensing fee allowed for legend drug prescriptions dispensed using a pharmacy packaging unit-doses blister card system:

(1) The dispensing fee for intravenous drugs which require mixing by the pharmacist is $8.00, except cancer chemotherapy IVS, which is $14.00, unless item (2), below, applies.

(2) The dispensing fee for total parenteral nutrition products which require mixing by the pharmacist is $30.00 for those dispensed in 1 liter quantity, and $44.00 for those dispensed in a quantity greater than 1 liter.

In addition, the State agency will receive a rebate for prescribed drugs in accordance with the manufacturer's contract with the Health Care Financing Administration.

12.b. Dentures.

Dentures are paid using the same methodology as item 10, Dental services.

12.c. Prosthetic devices.

Payment the lower of:

(1) submitted charge;

(2) Medicare fee schedule amount; or

(3) if Medicare has not established a payment amount for the prosthetic or orthotic device, an amount determined using one of the following methodologies:

(a) 50th percentile of the usual and customary charges submitted for the prosthetic or orthotic device for the previous calendar year minus 20 percent;

(b) if no information about usual and customary charges exists for the previous calendar year, payment is based upon the manufacturer's suggested retail price minus 20 percent; or

(c) if no information exists about the manufacturer's suggested retail price, payment is based upon the wholesale cost plus 20 percent.

MAR 09 2001

12.d. Eyeglasses.

Payment for eyeglasses and ophthalmaic materials is based on volume purchase contracting established through the competitive bidding process.

13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than those provided elsewhere in the plan.

See items 13.a. through 13.d.

13.a. Diagnostic services.

Diagnostic services are paid using the same methodology as item 5.a., Physicians' services.

13.b. Screening services.

Screening services are paid using the same methodology as item 5.a., Physicians' services.

13.c. Preventive services.

Preventive services are paid using the same methodology as item 5.a., Physicians' services.

14. Services for individuals age 65 or older in institutions for mental diseases.

See items 14.a. through 14.c.

14.a. Inpatient hospital services.

See Attachment 4.19-A.

14.b. Nursing facility services.

See Attachment 4.19-D.

14.c. Intermediate care facility for the mentally retarded (ICF/MR) services.

See Attachment 4.19-D.

15. Nursing facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31) of the Act, to be in need of such care.

See items 15.a. and 15.b.

15.a. Nursing services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31) of the Act, to be in need of such care.

See Attachment 4.19-D.

15.b. Intermediate care facility services (other than such services in an institution for mental diseases) in a public institution (or distinct part thereof) for persons with mental retardation or related conditions.

See Attachment 4.19-D.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

See Attachments 4.19-A and 4.19-D.

17. Nurse-midwife services.

Nurse-midwife services are paid using the same methodology as item 5.a., Physicians' services.

18. Hospice care (in accordance with section 1905(o) of the Act).

Payment is determined using basic payment rates for four levels of care and payment for physician services. Additional payment of a room and board amount is made for nursing home residents.

The fixed daily rates for the following four levels of care are determined using Medicare payment methodology except that no copayments are deducted.

(1) Routine Home Care Day
(2) Continuous Home Care Day
(3) Inpatient Respite Day
(4) General Inpatient Day

The fixed daily rates are designed to pay the hospice for the costs of all covered services related to the treatment of a recipient's terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made by the hospice.

Payment for room and board for hospice patients residing in long term care facilities is based on 95% of the case mix rate determined in accordance with the Medicaid payment methodology contained in Attachment 4.19-D. Payment is made to the hospice provider.

Payment for physician services not included in the fixed daily rate is based on the usual Medicaid payment methodology for physician services contained elsewhere in this Attachment. If the attending physician is an employee of the hospice or is providing services by arrangement with the hospice, the hospice is paid for the physician services. If the attending physician is not a hospice employee, payment is made directly to the physician provider in accordance with the usual Medicaid payment methodology for physician services contained elsewhere in this Attachment.

The limits and cap amounts are the same as used in the Medicare Program except that the inpatient day limit on both inpatient respite care days and general inpatient care days does not apply to recipients afflicted with acquired immunodeficiency syndrome (AIDS).

19. Case management services as defined in, and to the groups specified in, Supplements 1 and 1a to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

See items 19.a. and 19.b.

19.a. **Case management services** as defined in, and to the group specified in, **Supplement 1** to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

Payment is made on a monthly basis. Costs associated with mentoring, supervision and continuing education may be included in the monthly rate. Payment is limited to the components listed in **Supplement 1** to Attachments 3.1-A/B, "Definition of Services."

1. The monthly rate for case management services provided by **state or county staff** is based on an aggregate of time spent performing all elements of case management services. There are separate rates for adults and children.

2. The rate for case management services provided by **entities under contract with a county** is based on the monthly rate negotiated by the county. The negotiated rate must not exceed the rate charged by the entity for the same service to other payers.

   A. If the service is provided by a team of contracted vendors, the county may negotiate a team rate with a vendor who is a member of the team. The team must determine how to distribute the rate among its members. No payment received by contracted vendors will be returned to the county, except to pay the county for advance funding provided by the county to the vendor.

   B. If the service is provided by a team which includes contracted vendors and state or county staff, the costs for state or county staff participation in the team must be included in the rate for county-provided services. In this case, the contracted vendor and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, the county must document, in the client's file, the need for team case management and a description of the roles of the team members.

19.a. **Case management services** as defined in, and to the group specified in, **Supplement 1** to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act). (continued)

Rate Methodology for County and State Staff:

Beginning July 1, 2000, a statistically valid random moment time study, Minnesota's Social Service Time Study (SSTS), is used to construct a monthly rate for mental health case management services. The SSTS separates time of all direct service staff into a number of categories that constitute allowable mental health case management activities and other, unallowable activities. The proportion of allowable to total activities, when multiplied by the overall provider costs, establishes the costs of mental health case management activity.

The percentage of time spent by service staff on allowable mental health case management services for children and adults is applied to the annual costs of providing social services, and divided by twelve to arrive at the eligible cost per month. These figures are divided by the average number of children and adults who received mental health case management services per month. The result is two separate, monthly payment rates for mental health case management, one for children and one for adults.

The two rates represent one month's worth of eligible mental health case management activity. Only one claim per client is allowed per calendar month for mental health case management services provided by county and state staff. The rate is the same for medical assistance-eligible and non-medical assistance eligible clients. All of the following conditions must be met in order for a claim to be made:

- the client must be eligible for medical assistance;
- the client received mental health case management services in that month; and
- all documentation requirements are met.

The rate will be reviewed and updated annually, using the most current, available data.

19.a. **Case management services** as defined in, and to the group specified in, **Supplement 1** to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act. (continued)

Rate Formula:

CP = Average Monthly Social Services Cost Pool for the most recent year for that class of providers

P = Percentage of eligible mental health case management time as identified on the most recent year of the SSTS for that class of providers

N = Monthly Average number of clients receiving mental health case management services for that class for providers using the most recent year's worth of data

(CP x P) = Monthly costs of providing targeted mental health case management (TCM) services for that class of providers

TCM/N = TCM monthly rate for that class of providers

Interim Rate Methodology: July 1, 1999 through June 30, 2000:

Because the mental health case management rates prior to July 1, 1999, are flat, hourly rates for children and adults, the actual percent time of eligible case management services time is not available in the SSTS for the period July 1, 1998 through June 30, 1999. For that reason, from July 1, 1999 through June 30, 2000, the first year of the new methodology, an interim rate will be developed. The interim rate will be determined using county time reported in the Social Services Expenditures and Grant Reconciliation Report (SEAGR) for calendar year 1998, and the total number of clients served will be taken from a special survey conducted April, 1999, for the quarter January through March, 1999.

19.a. **Case management services** as defined in, and to the group specified in, **Supplement 1** to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act. (continued)

In order for a claim to be made for this period, the same conditions must be met as described above as of July 1, 2000.

Interim Rate Formula:

CP x P(SEAGR) x 1.05 (inflation factor) ÷ N (survey data)

At the end of the interim period (June 30, 2000), the Department will settle-up with the counties, using SSTS data reported during the interim rate period.

Settle-Up Rate Formula:

The formula described on page ~~56b~~ 57b: CP x P ÷ N.

19.b. **Child welfare-targeted case management services** as defined in, and to the group specified in, **Supplement 1a** to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

The monthly rate is based on an aggregate of time spent performing all elements of case management services.

Payment is based on:

a. A face-to-face contact at least once per month between the case manager and the recipient or the recipient's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan in regard to the status of the recipient, the individual service plan, or goals for the recipient.

b. A telephone contact, for Minnesota recipients placed outside the county of financial responsibility in an excluded time facility under Minnesota Statutes, section 256G.02, subdivision 6, or through the Interstate Compact on the Placement of Children, Minnesota Statutes, section 260.851, and the placement in either case is more than 60 miles beyond the county boundaries. The telephone contact must be between the case manager and the recipient or the recipient's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan in regard to the status of the recipient, the individual service plan, or goals for the recipient. There must be at least one contact per month and not more than two consecutive months without a face-to-face contact as described in item a., above.

Rate Methodology for IHS or Tribal 638 Providers:

Payment is $178 per encounter. This amount is the average of the monthly rate in the counties' Contract Health Service Delivery Area of federally-recognized reservations divided by two encounters per month. The rate will be recalculated annually.

19.b. **Child welfare-targeted case management services** as defined in, and to the group specified in, **Supplement 1a** to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act. (continued)

An encounter is defined as a face-to-face contact or a telephone contact occurring within a 24-hour period ending at midnight, as follows:

a. A face-to-face contact between the case manager and the recipient or recipient's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan in regard to the status of the recipient, the individual service plan, or goals for the recipient.

b. A telephone contact between the case manager and the recipient or recipient's family, primary caregiver legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan in regard to the status of the recipient, the individual service plan, or goals for the recipient.

This applies to a recipient placed outside the county of financial responsibility or to a recipient served by tribal social services placed outside the reservation, in an excluded time facility under Minnesota Statutes, section 256G.02, subdivision 6, or through the Interstate Compact on the Placement of Children under Minnesota Statutes, section 260.851. The placement must be more than 60 miles beyond the county or reservation boundaries.

To be eligible for payment, there must be at least one contact per month and not more than two consecutive months without a face-to-face contact.

Only one contact within a 24-hour period will be paid, except that encounters with more than one case manager in the same 24-hour period are payable if one case manager from a tribe and one case manager from the county of financial responsibility or a tribal-contracted vendor

19.b. **Child welfare-targeted case management services** as defined in, and to the group specified in, **Supplement 1a** to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act. (continued)

determine that dual case management is medically necessary and documentation of the need and the distinctive services provided by each case manager is maintained in the individual service plan.

Rate Methodology for Entities Under Contract with a County or Tribal Social Services

The monthly rate for child welfare-targeted case management services provided by entities under contract with a county or tribal social services is based on the monthly rate negotiated by the county or tribal social services. The negotiated rate must not exceed the rate charged by the entity for the same service to other payers.

a. If the service is provided by a team of contracted vendors, the county or tribal social services may negotiate a team rate with a vendor who is a member of the team. The team must determine how to distribute the rate among its members.

b. If the service is provided by a team that includes contracted vendors and county or tribal social services staff, the costs for county or tribal social services staff participation in the team must be included in the rate for county or tribal social services-provided services. In this case, the contracted vendor and the county or tribal social services may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team child-welfare targeted case management and a description of the roles of the team members.

19.b. **Child welfare-targeted case management services** as defined in, and to the group specified in, **Supplement 1a** to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act. (continued)

Rate Methodology for County Staff:

A statistically valid random moment time study, Minnesota's Social Service Time Study (SSTS), is used to construct a monthly rate for child welfare-targeted case management. The SSTS separates a case manager's time into a number of categories which constitute allowable case management activities and other, unallowable activities. The proportion of allowable to total activities, when multiplied by the over-all provider costs establishes the costs of case management activity.

The percentage of time spent by service staff on allowable child welfare-targeted case management services is applied to quarterly costs of providing social services, and divided by three to arrive at the eligible cost per month. This figure is divided by the average number of clients who received case management services per month. The result is the rate used for child welfare-targeted case management. This process is repeated so that valid rates can be established for each class of providers. The SSTS will be valid at each class.

The rate represents one month's worth of eligible child welfare-targeted case management activity and only one claim is allowed per calendar month. The rate is the same for MA-eligible and non-MA-eligible children. In the payment process, *all* of the following conditions must be met in order for a claim to be made:

A. the child is a MA recipient;
B. the child received child welfare-targeted case management services that month; and
C. all documentation requirements are met.

The rate will be reviewed and updated annually, using the most current, available data.

19.b. **Child welfare-targeted case management services** as defined in, and to the group specified in, **Supplement 1a** to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act. (continued)

Rate Formula:

CP = Average Quarterly Social Service Cost Pool for the most recent year for that class of providers

P = Percentage of eligible targeted case management time as identified on the most recent year of the SSTS for that class of providers

N = Monthly Average number of children receiving case management services for that class of providers using the most recent year's worth of data

(CP/3 x P) = Monthly costs of providing child welfare-targeted case management (TCM) for that class of providers

TCM/N = CW-TCM monthly rate for that class of providers